FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026484

Facility Name: LAKEVIEW NURSING & REHABILITATION CENTER

Address: 735 WEST DIVERSEY (Number) CHICAGO (City) 60614 (Zip Code)

County: COOK

Telephone Number: (847) 784-8204 **Fax #** (847) 784-8248

IDPA ID Number: 36-3133316

Date of Initial License for Current Owners: 08/14/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JOHN BERNARDI

(Title) CFO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3	117	Intermediate (ICF)	117	42,705	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,681	259	11,440	13,380	8
9	SNF/PED					9
10	ICF	43,317	3,635	41	46,993	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,998	3,894	11,481	60,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.89%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 08/15/81

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 08/14/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 63 and days of care provided 9,303

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATI(# 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,126	40,646	21,289	389,061		389,061		389,061			1
2	Food Purchase		275,427		275,427	(15,659)	259,768		259,768			2
3	Housekeeping	302,972	37,064		340,036		340,036		340,036			3
4	Laundry	80,344	20,701	2,877	103,922		103,922		103,922			4
5	Heat and Other Utilities			171,912	171,912		171,912		171,912			5
6	Maintenance	96,271	38,568	36,472	171,311		171,311	1,151	172,462			6
7	Other (specify):*			15,835	15,835		15,835		15,835			7
8	**TOTAL General Services**	806,713	412,406	248,385	1,467,504	(15,659)	1,451,845	1,151	1,452,996			8
	B. Health Care and Programs											
9	Medical Director			43,000	43,000		43,000		43,000			9
10	Nursing and Medical Records	2,739,489	177,197	6,260	2,922,946		2,922,946		2,922,946			10
10a	Therapy	450,757	3,175		453,932		453,932		453,932			10a
11	Activities	101,676	1,190	8,586	111,452		111,452		111,452			11
12	Social Services	78,737		1,925	80,662		80,662		80,662			12
13	CNA Training											13
14	Program Transportation			1,939	1,939		1,939		1,939			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,370,659	181,562	61,710	3,613,931		3,613,931		3,613,931			16
	C. General Administration											
17	Administrative	433,313		343,500	776,813		776,813		776,813			17
18	Directors Fees											18
19	Professional Services			97,958	97,958		97,958		97,958			19
20	Dues, Fees, Subscriptions & Promotions			154,731	154,731		154,731	(64,604)	90,127			20
21	Clerical & General Office Expenses	386,024	50,277	91,090	527,391		527,391	(186,943)	340,448			21
22	Employee Benefits & Payroll Taxes			948,657	948,657	15,659	964,316		964,316			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,161	13,161		13,161		13,161			24
25	Other Admin. Staff Transportation			15,212	15,212		15,212		15,212			25
26	Insurance-Prop.Liab.Malpractice			198,896	198,896		198,896		198,896			26
27	Other (specify):*											27
28	**TOTAL General Administration**	819,337	50,277	1,863,205	2,732,819	15,659	2,748,478	(251,547)	2,496,931			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,996,709	644,245	2,173,300	7,814,254		7,814,254	(250,396)	7,563,858			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: LAKEVIEW NURSING & REHABILITATION CEN #0026484 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	17,680	
	REPAIRS & MAINTENANCE		3,609	
			0	21,289
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,877	
			0	2,877
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		77,461	
	ELECTRICITY		71,390	
	WATER		21,016	
	CABLE TV - LOBBY		2,045	
			0	171,912
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,300	
	PAINTING & DECORATING		823	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		21,708	
	ELEVATOR MAINTENANCE & REPAIR		5,905	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,102	
	FIRE SERVICE		4,634	
			0	
			0	
			0	36,472
7	**OTHER**			
	SCAVENGER		13,560	
	SECURITY SERVICE		2,275	15,835
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	43,000	43,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,224	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	2,036	
			0	
			0	6,260
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		6,186	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,400	
			0	8,586
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,925	
			0	1,925
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER #0026484 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,939	1,939
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	343,500	343,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,076	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	85,882	
			0	97,958
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	37,390	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,664	
	EMPLOYEE WANT ADS	XIX F	62,016	
	CONTRIBUTIONS	VI 20 XIX F	7,920	
	DUES & SUBSCRIPTIONS	XIX F	17,293	
	LICENSES & PERMITS	XIX F	8,465	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	3,073	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,557	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,353	154,731
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		18,669	
	EQUIPMENT REPAIR & MAINTENANCE		29,001	
	OUTSIDE CLERICAL SERVICES		400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,330	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		40,293	
	MESSENGER SERVICE		1,397	
			0	91,090

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	373,130	
	UNEMPLOYMENT COMPENSATION	XIX D	63,684	
	WORKERS COMPENSATION INSURANCI	XIX D	121,838	
	HOSPITALIZATION INSURANCE	XIX D	316,634	
	EMPLOYEE BENEFITS - OTHER	XIX D	27,117	
	EMPLOYEE PHYSICAL EXAMS	XIX D	70	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	46,184	
	CHICAGO HEAD TAX	XIX D	0	948,657
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	6,916	
	TRAVEL	XIX G	6,245	
			0	
			0	13,161
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,212	15,212
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		198,896	198,896
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 2,173,300

LAKEVIEW NURSING & REHABILITATION CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	275,427	PATIENT MEALS	181119
LESS SALES TAX	0	ADD EMPLOYEE MEALS	10950
NET FOOD	275,427	TOTAL MEALS/YEAR	192069
TOTAL PATIENT CENSUS	60,373	NET FOOD	275427
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	192069
TOTAL PATIENT MEALS	181119	COST PER MEAL	1.43
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30	EMPLOYEE MEAL RECLASSIFICATION	15659
TIME # DAYS	365		
TOTAL EMPLOYEE MEALS	10950		

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER #0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			111,975	111,975		111,975	124,626	236,601			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,399	100,399		100,399	563,221	663,620			32
33	Real Estate Taxes							163,747	163,747			33
34	Rent-Facility & Grounds			945,115	945,115		945,115	(945,115)				34
35	Rent-Equipment & Vehicles			72,206	72,206		72,206		72,206			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,229,695	1,229,695		1,229,695	(93,521)	1,136,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		416,120	41,562	457,682		457,682		457,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		416,120	140,112	556,232		556,232		556,232			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,996,709	1,060,365	3,543,107	9,600,181		9,600,181	(343,917)	9,256,264			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTEI # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,152)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,330)	21		18
19	Entertainment	(37,390)	20		19
20	Contributions	(10,477)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(13,664)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,073)	20		28
29	Other-Attach Schedule SEE PAGE 5-A	(184,462)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (254,548)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(89,369)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (89,369)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (343,917)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LAKEVIEW NURSING & REHABILITATION CENTER

ID# 0026484

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,151	6	1
2	MARKETING SALARIES	(185,613)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(184,462)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,151	0	0	0	0	0	0	0	0	0	0	1,151	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,151	0	0	0	0	0	0	0	0	0	0	1,151	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(64,604)	0	0	0	0	0	0	0	0	0	0	(64,604)	20
21	Clerical & General Office Expenses	(186,943)	0	0	0	0	0	0	0	0	0	0	(186,943)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(251,547)	0	0	0	0	0	0	0	0	0	0	(251,547)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(250,396)	0	0	0	0	0	0	0	0	0	0	(250,396)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,152)	128,778	0	0	0	0	0	0	0	0	0	124,626	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	563,221	0	0	0	0	0	0	0	0	0	563,221	32
33	Real Estate Taxes	0	163,747	0	0	0	0	0	0	0	0	0	163,747	33
34	Rent-Facility & Grounds	0	(945,115)	0	0	0	0	0	0	0	0	0	(945,115)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,152)	(89,369)	0	0	0	0	0	0	0	0	0	(93,521)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(254,548)	(89,369)	0	0	0	0	0	0	0	0	0	(343,917)	45

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM BOREK	50			BOREK &		
HILLARD GARLOVSKY	50			GOLDHIRSCH	WILMETTE	LAW FIRM
				735 W. DIVERSEY		
				BUILDING, LLC	CHICAGO	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 945,115	735 WEST DIVERSEY BUILDING, LLC		$	$ (945,115)	1
2	V	30	SL DEPRESIATIN				128,778	128,778	2
3	V	32	INTEREST				563,221	563,221	3
4	V	33	REAL ESTATE TAX				163,747	163,747	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 945,115			$ 855,746	$ * (89,369)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITAT # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SAM BOREK	PRESIDENT	ADMINISTRAT.	50.00		30	60.00	SALARY	$ 162,398	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 162,398		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: 735 WEST DIVERSEY BUILDING LLC
Street Address: 735 W DIVERSEY
City / State / Zip Code: CHICAGO, IL 60614
Phone Number: (773) 349-4055
Fax Number: (773) 348-0684

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	SL DEPRECIATION	DIRECT COST	1	1	$ 128,778	$	1	$ 128,778	1
2	32	INTEREST	DIRECT COST	1	1	563,221		1	563,221	2
3	33	REAL ESTATE TAX	DIRECT COST	1	1	163,747		1	163,747	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 855,746	$		$ 855,746	25

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATI # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: 735 WEST DIVERSEY BUILDING, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$77,801.29	05/04	10,055,500	9,910,616	05/39	5.6000	557,533	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		199,085	189,842			5,688	3
4												4
5	MANUFACTURES BANK		X	LOAN	DEMAND	12/22/04	600,000	416,663	02/08	PRIME+	33,410	5
	Working Capital											
6	MANUFACTURES BANK	X		WORKING CAPITAL	DEMAND		1,377,000	1,308,961		PRIME+	62,264	6
7	GLENVIEW STATE BANK		X	AUTO				24,910			773	7
8	MEPCO INSURANCE		X	INSURANCE FINANCE							3,952	8
9	TOTAL Facility Related				$77,801.29		$ 12,231,585	$ 11,850,992			$ 663,620	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 12,231,585	$ 11,850,992			$ 663,620	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER **#** 0026484 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	163,747	2
3. Under or (over) accrual (line 2 minus line 1).	$	163,747	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	163,747	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	174,760	8
2001	183,591	9
2002	177,670	10
2003	162,353	11
2004	163,747	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKEVIEW NURSING & REHABILITATION CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026484

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-300-013-0000	NURSING HOME	$ 163,746.60	$ 163,746.60
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 163,746.60	$ 163,746.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,604 B. General Construction Type: Exterior BRICK Frame BRICK & STEEL Number of Stories 3 & BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2001	$ 558,037	1
2					2
3	TOTALS			$ 558,037	3

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		2001		$ 5,022,332	$ 128,778	39	$ 128,778	$	$ 617,216	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1982	2,850					2,850	9
10	LEASEHOLD IMPROVEMENTS			1983	2,500		15			2,500	10
11	LEASEHOLD IMPROVEMENTS			1985	2,312		10			2,312	11
12	LEASEHOLD IMPROVEMENTS			1985	3,200		20	160	160	3,120	12
13	LEASEHOLD IMPROVEMENTS			1987	29,042	922	20	1,452	530	25,926	13
14	LEASEHOLD IMPROVEMENTS			1987	8,647	275	31.5	275		4,946	14
15	LEASEHOLD IMPROVEMENTS			1988	13,520	429	31.5	429		7,642	15
16	LEASEHOLD IMPROVEMENTS			1989	17,460	554	5		(554)	17,460	16
17	LEASEHOLD IMPROVEMENTS			1989	6,534	207	15	264	57	6,798	17
18	LEASEHOLD IMPROVEMENTS			1990	20,612	654	31.5	654		10,464	18
19	LEASEHOLD IMPROVEMENTS			1991	40,916	1,299	31.5	1,299		18,835	19
20	LEASEHOLD IMPROVEMENTS			1992	40,819	1,296	31.5	1,296		17,564	20
21	LEASEHOLD IMPROVEMENTS			1993	10,482	333	31.5	333		4,274	21
22	LEASEHOLD IMPROVEMENTS			1993	16,965	435	39	435		5,303	22
23	LEASEHOLD IMPROVEMENTS			1994	9,602	246	39	246		2,881	23
24	ROOF REPAIR			1995	3,188	82	39	82		866	24
25	SHOWER RECONSTRUCTION			1995	7,775	200	39	200		2,002	25
26	SHOWER ROOMS RENOVATION			1996	35,634	914	39	914		8,767	26
27	OFFICE CONSTRUCTION			1996	4,647	119	39	119		1,124	27
28	ELECTRIC SLIDING DOOR			1996	1,380	35	39	35		321	28
29	BRICKWORK/TUCKPOINT			1997	1,680	43	39	43		374	29
30	PARKING LOT			1997	1,900	49	39	49		525	30
31	CLOSET WORK			1997	800	20	39	20		177	31
32	CONSULTING AND INSTALL FIREDOORS			1997	23,621	606	39	606		4,919	32
33	FIRE ALARM PANEL			1998	3,500	90	39	90		701	33
34	ROOF EXHAUST FANS, INSTALLATION FIRE DAMPTERS			1998	20,698	531	39	531		4,090	34
35	FRONT PORCH ENTRANCE, ONE MARQUEE CANOPY			1998	2,247	57	39	57		433	35
36	SMOKE DAMPERS			1998	1,669	43	39	43		317	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALK IN FREEZER-NEW CONDENSING UNIT	1998	$ 5,546	$ 142	39	$ 142	$	$ 1,024	37
38	CEILING & LIGHT FIXTURES, ELECTRICAL	1998	30,226	775	39	775		5,459	38
39	CAFETERIAS - 1ST AND 3RD FLOOR	1999	3,000	77	39	77		529	39
40	LIGHTING, ELECTRICAL WORK, INSTALL CABLE	1999	27,482	705	39	705		4,824	40
41	DOORS REPAIR & PAINT-1ST,2ND AND 3RD FLOOR	1999	25,070	643	39	643		4,286	41
42	PLUMBING ROUGH	1999	10,300	264	39	264		1,771	42
43	PAINT WORK-1ST,END,3RD FLOOR, BASEMENT	1999	21,014	539	39	539		3,481	43
44	WALLCOVERING, CARPET TILES	1999	55,627	1,426	39	1,426		9,255	44
45	GENERATOR EXHAUST PIPE	1999	2,300	59	39	59		391	45
46	HANDRAILS-1ST,2ND,3RD FLOOR, BASEMENT	1999	24,340	624	39	624		4,106	46
47	ALARM SYSTEM	1999	107,758	2,763	39	2,763		18,715	47
48	DINING ROOM - 2ND AND 3RD FLOOR	1999	12,206	313	39	313		2,024	48
49	SHOWER AND FRONT STOOP REPAIR	1999	4,300	110	39	110		704	49
50	WINDOWS, CLOSETS, EXTERIOR	1999	4,415	113	39	113		639	50
51	INSTALLATION OF THE FIRE DAMPERS	1999	5,880	151	39	151		1,038	51
52	PLEATED SHADES	2000	949		20	47	47	282	52
53	CANVAS CANOPY	2000	3,996	102	39	102		593	53
54	INSTALLATION OF COOLING TOWER	2000	24,450	627	39	627		3,578	54
55	ALARM SYSTEM - ADDITIONAL PROTECTION	2000	1,970	51	39	51		291	55
56	DIALYSIS ROOM EXTRA CIRCUITS	2000	1,983	51	39	51		291	56
57	MICROLIGHT DETECTORS	2000	3,800	97	39	97		534	57
58	REPAIR DRYWALL	2000	3,744	96	39	96		505	58
59	ELECTRICAL PANEL FOR DIALYSIS CENTER	2000	2,380	61	39	61		318	59
60	INSTALLED 9 DOOR HOLDERS	2000	3,465	89	39	89		456	60
61	REMODELING NEW NORTHFIELD OFFICE	2001	3,440	88	39	88		437	61
62	TWO PASSENGER ELEVATOR	2001	84,711	2,172	39	2,172		9,503	62
63	TUCKPOINTING	2001	3,160	81	39	81		341	63
64	REPAVE DRIVEWAY & PARKING LOT	2001	7,000	179	39	179		777	64
65	ELECTRICAL WORK	2001	11,922	306	39	306		1,273	65
66	ROOF REPAIR	2001	7,945	204	39	204		873	66
67	PAINTING, WALLPAPERING, DRYWALL	2001	42,598	1,092	39	1,092		6,533	67
68	BACKUP GENERATOR	2002	6,375	163	39	163		646	68
69	ELECTRICAL WORK	2002	5,000	128	39	128		507	69
70	TOTAL (lines 4 thru 69)		$ 5,914,884	$ 152,508		$ 152,748	$ 240	$ 860,691	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,914,884	$ 152,508		$ 152,748	$ 240	$ 860,691	1
2	ROOF & GUTTER REPAIR	2002	7,000	180	39	180		712	2
3	FLOORING & TILE IN CAFETERIA	2002	5,368	138	20	268	130	1,072	3
4	REPAIR DRIVEWAY & PARKING LOT	2002	3,300	85	15	220	135	880	4
5	CABINET INSTALLATION IN MAINTENANCE ROOM	2002	3,200	82	39	82		311	5
6	CARPETING INSTALLATION IN WAITING AREA	2002	3,561	91	20	178	87	712	6
7	REPLACE CABLE IN ELEVATOR	2002	5,800	149	39	149		552	7
8	BATHROOM SHOWER	2003	8,075	207	39	207		526	8
9	BOILER RE-TUBING	2003	21,850	560	39	560		1,330	9
10	CARPETING AND SHADES	2003	5,186	1,182	20	259	(923)	777	10
11	PLUMBING REVISIONS FOR DIALYSIS LOOP PIPING	2004	14,993	545	27.5	545		795	11
12	SPRINKLER SYSTEM & FIRE ALARM REPAIR	2005	6,556	149	27.5	149		149	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,999,773	$ 155,876		$ 155,545	$ (331)	$ 868,507	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CE! # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 533,937	$ 35,489	$ 51,453	$ 15,964	10 YRS	$ 322,315	71
72	Current Year Purchases	205,192	41,038	10,259	(30,779)	10 YRS	10,259	72
73	Fully Depreciated Assets	553,184					553,184	73
74								74
75	TOTALS	$ 1,292,313	$ 76,527	$ 61,712	$ (14,815)		$ 885,758	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMINISTRATIVE	1999 BLAZER	1999	$ 34,882	$ 1,775	$	$ (1,775)	5	$ 34,882	76
77	ADMINISTRATIVE	1999 MERCEDES	2001	53,242	1,775	10,649	8,874	5	53,241	77
78	ADMINISTRATIVE	2004 LEXUS	2004	43,476	4,800	8,695	3,895	5	17,390	78
79										79
80	TOTALS			$ 131,600	$ 8,350	$ 19,344	$ 10,994		$ 105,513	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,981,723	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 240,753	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 236,601	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,152)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,859,778	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 54,998 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2004 TOYOTA WAGON	$ 534.00	$ 6,498	17
18	ADMINISTRATIVE	2005 PORSCHE	#######	10,710	18
19					19
20					20
21	TOTAL		$ #######	$ 17,208	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-2	hrs			5,166			5,166	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			36,396			36,396	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				261,213		261,213	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, RESPIRATORY,LAB Other (specify): MED.SUPPLIES,REN	39-3 39-3					56,339 98,568		56,339 98,568	13
14	TOTAL			$		$ 41,562	$ 416,120		$ 457,682	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,488	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,155,870		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,745		6
7	Other Prepaid Expenses	6,960		7
8	Accounts Receivable (owners or related parties)	916,426		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,181,489	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	977,441		15
16	Equipment, at Historical Cost	1,423,913		16
17	Accumulated Depreciation (book methods)	(1,371,858)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION ESCROW	167,846		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,197,342	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,378,831	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 719,465	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,342		28
29	Short-Term Notes Payable	1,966,623		29
30	Accrued Salaries Payable	117,120		30
31	Accrued Taxes Payable (excluding real estate taxes)	59,779		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,894,329	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,894,329	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,484,502	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,378,831	$	48

***(See instructions.)**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,283,018	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,283,018	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,484	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 201,484	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,484,502	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CI # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,514,506	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,514,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	284,039	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 284,039	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	472	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 472	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,648	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,648	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,801,665	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,467,504	31
32	Health Care	3,613,931	32
33	General Administration	2,732,819	33
	B. Capital Expense		
34	Ownership	1,229,695	34
	C. Ancillary Expense		
35	Special Cost Centers	457,682	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,600,181	40
41	**Income before Income Taxes (line 30 minus line 40)****	201,484	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 201,484	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	2,106	$ 94,177	$ 44.72	1
2	Assistant Director of Nursing	3,085	3,296	115,350	35.00	2
3	Registered Nurses	34,880	37,241	982,836	26.39	3
4	Licensed Practical Nurses	20,212	21,761	479,533	22.04	4
5	CNAs & Orderlies	95,485	102,231	992,755	9.71	5
6	CNA Trainees					6
7	Licensed Therapist	1,768	1,891	53,816	28.46	7
8	Rehab/Therapy Aides	17,198	18,570	396,941	21.38	8
9	Activity Director	2,032	2,130	27,542	12.93	9
10	Activity Assistants	9,237	9,693	74,134	7.65	10
11	Social Service Workers	3,900	4,361	78,737	18.05	11
12	Dietician					12
13	Food Service Supervisor	1,988	2,117	40,890	19.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,128	29,550	286,236	9.69	15
16	Dishwashers					16
17	Maintenance Workers	5,690	6,081	96,271	15.83	17
18	Housekeepers	29,600	31,385	302,972	9.65	18
19	Laundry	7,835	8,521	80,344	9.43	19
20	Administrator	4,193	4,416	309,034	69.98	20
21	Assistant Administrator	1,962	2,227	45,230	20.31	21
22	Other Administrative	1,877	2,086	79,049	37.90	22
23	Office Manager					23
24	Clerical	14,317	15,498	194,059	12.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,997	2,110	32,626	15.46	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	8,607	9,486	234,177	24.69	33
34	TOTAL (lines 1 - 33)	294,903	316,757	$ 4,996,709 *	$ 15.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 17,680	1-3	35
36	Medical Director	MONTHLY	43,000	9-3	36
37	Medical Records Consultant	MONTHLY	4,224	10-3	37
38	Nurse Consultant	34	2,036	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,400	11-3	44
45	Social Service Consultant	38	1,925	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	120	$ 71,265		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides	N/A	0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CEN # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL ELKES	ADMIN	0	$ 146,636
BARBARA GONZALES	ASST ADMIN	0	45,230
SAM BOREK	PRESIDENT	50	162,398
JOHN BERNARDI	OFFICE MANAGER	0	79,049
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 433,313

B. Administrative - Other

Description	Amount
CONSULTANTS FOR CORPORATE MANAGEMENT	$ 343,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 343,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		97,958
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 97,958

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 121,838
Unemployment Compensation Insurance		63,684
FICA Taxes		373,130
Employee Health Insurance		316,634
Employee Meals		15,659
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		27,117
EMPLOYEE PHYSICAL EXAMS		70
PENSION/PROFIT SHARING PLANS		46,184
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 964,316

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	62,016
Health Care Worker Background Check	2,353
(Indicate # of checks performed 168)	
MARKETING/ADV/PROMO	54,127
TRUST/FRANCHISE/CONTRIB/ETC	10,477
LICENSES & PERMITS	8,465
DUES & SUBSCRIPTIONS	17,293
TRUST/FRANCHISE/CONTRIB/ETC	(10,477)
Less: Public Relations Expense	(37,390)
Non-allowable advertising	(13,664)
Yellow page advertising	(3,073)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 90,127

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,245
In-State Travel	
Seminar Expense	
	6,916
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,161

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTE # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2	PAINT/DECORATING	2002	2,025	3 YRS	338	675	675	337					
3	PAINT/DECORATING	2004	2,443	3 YRS			408	814	814	407			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,468		$ 338	$ 675	$ 1,083	$ 1,151	$ 814	$ 407	$	$	$

Facility Name & ID Number LAKEVIEW NURSING & REHABILITATION CENTER # 0026484 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8262**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **NO**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,550**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,659** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees